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Medicare and Medicaid Fraud and Abuse-Alice G. Gosfield 2005
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Medicare-United States. General Accounting Office 1991
Health Care Fraud and Abuse-Linda A. Baumann 2013
Medicare and Medicaid Fraud and Abuse-Saul, Ewing, Remick & Saul 1992-06-01
Medicare improper payments challenges for measuring potential fraud and abuse remain despite planned enhancements-
Medicare Fraud and Abuse-U. S. Congress, Senate Committee on Finance Staff 1997
Medicare Fraud and Abuse-United States 1992
Waste, Fraud, and Abuse in the Medicare Program-United States. Congress. House. Committee on Commerce. Subcommittee on Health and the Environment 1995
Health Care Fraud and Abuse-Hoyt W. Torras 2003 A guide for physicians covering the legal aspects of health insurance and offers ways to design an effective billing, coding, and accounts receivable process.
Medicare-medicaid Antifraud and Abuse Amendments-United States. Congress. House. Committee on Ways and Means. Subcommittee on Health 1977
Legal Issues in Health Care Fraud and Abuse-David E. Matyas 2006
Ethical Challenges in the Management of Health Information-Laurinda B. Harman 2001 Resource added for the Health Information Technology program 105301.
Medicare & You Handbook 2020-CMS U. S. Centers for Medicare 2020-04-13 Medicare & You Handbook 2020 Find out about Medicare coverage in 2020, including Medicare Part A, Part B, Part C (Medicare Advantage), Part D, and Medicare Supplements (Medigap).
Medicare and Medicaid Fraud,Waste, and Abuse-
Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments-Kathleen M. King 2010-10 Medicare¿s size and complexity make it vulnerable to fraud, waste, and abuse. Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain, while abuse represents actions inconsistent with acceptable bus. or med. practices. Waste, which includes inaccurate payments for services, also occurs in the Medicare program. In 2009, the Centers for Medicare and Medicaid Services (CMS) estimated billions of dollars in improper payments in the Medicare program. This statement focuses on challenges facing CMS and selected key strategies that are particularly important to helping prevent fraud, waste, and abuse, and ultimately to reducing improper payments. Illustrations.
Fraud and Abuse-Sarah F. Jaggar 1995
License To Steal-Malcolm K Sparrow 2007-12-14 Who steals? An extraordinary range of folk--from low-life hoods who sign on as Medicare or Medicaid providers equipped with nothing more than beepers and mailboxes, to drug trafficking organizations, organized crime syndicates, and even major hospital chains. In License to Steal, Malcolm K. Sparrow shows how the industry's defenses, which focus mostly on finding and correcting billing errors, are no match for such well orchestrated attacks. The maxim for thieves simply becomes "bill your lies correctly." Provided they do that, fraud perpetrators with any degree of sophistication can steal millions of dollars with impunity, testing payment systems carefully, and then spreading fraudulent billings widely enough across patient and provider accounts to escape detection. The kinds of highly automated, quality controlled claims processing systems that pervade the industry present fraud perpetrators with their favorite kind of target: rich, fast paying, transparent, utterly predictable check printing systems, with little threat of human intervention, and with the U.S. Treasury on the end of the electronic line. Sparrow picks apart the industry's response to the government's efforts to control this problem. The provider associations (well heeled and politically influential) have vociferously opposed almost every recent enforcement initiative, creating the unfortunate public impression that the entire health care industry is against effective fraud control. A significant segment of the industry, it seems, regards fraud and abuse not as a problem, but as a lucrative enterprise worth defending. Meanwhile, it remains a perfectly commonplace experience for patients or their relatives to examine a medical bill and discover that half of it never happened, or that; likewise, if patients then complain, they discover that no one seems to care, or that no one has the resources to do anything about it.Sparrow's research suggests that the growth of capitated managed care systems does not solve the problem, as many in the industry had assumed, but merely changes its form. The managed care environment produces scams involving underutilization, and the withholding of medical care schemes that are harder to uncover and investigate, and much more dangerous to human health. Having worked extensively with federal and state officials since the appearance of his first book on this subject, Sparrow is in a unique position to evaluate recent law enforcement initiatives. He admits the "war on fraud" is at least now engaged, but it is far from won.
Health Care Fraud and Abuse Control Program-Daniel R. Levinson 2010-10 During FY 2009, the Fed. Gov¿t. won or negotiated approx. $1.63 billion in judgments and settlements, and it attained additional admin. impositions in health care fraud cases and proceedings. The Medicare Trust Fund received transfers of approx. $2.51 billion during this period as a result of these efforts, as well as those of preceding years, in addition to over $441 million in Fed. Medicaid money similarly transferred separately to the Treasury as a result of these efforts. The Health Care Fraud and Abuse Control Program account has returned over $15.6 billion to the Medicare Trust Fund since the inception of the Program in 1997. In FY 2009, U.S. Attorneys' Offices opened 1,014 new criminal health care fraud investigations involving 1,786 defendants. Illus.
Fraud, Abuse and Overpayments in the Medicare and Medicaid Programs-Bentley Orr 2020-03-03 Chapter 1 focuses on how the Centers for Medicare and Medicaid Services (CMS) identifies and combats waste, fraud, and abuse in both traditional Medicare and the Medicare Advantage program. Reducing improper payments is critical for protecting the integrity of the program and ensuring that taxpayer dollars are well spent. The Medicaid program, which provides vital health care to over 70 million Americans, regardless of preexisting conditions. GAO and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) published reports on continued weaknesses and program integrity risks and Medicaid managed care. Clearly, there is a need for greater transparency on how managed care organizations spend Federal dollars and greater program integrity and oversight in Medicaid in general. Chapter 2 talks about the rate of improper payments in the Medicaid program.
H.R. 3, Medicare-medicaid Anti-fraud and Abuse Amendments-United States. Congress. House. Committee on Ways and Means. Subcommittee on Health 1977
O'Connor's Texas Rules-Michol O'Connor 2007-01-01
Variation in Health Care Spending-Institute of Medicine 2013-10-01 Health care in the United States is more expensive than in other developed countries, costing $2.7 trillion in 2011, or 17.9 percent of the national gross domestic product. Increasing costs strain budgets at all levels of government and threaten the solvency of Medicare, the nation's largest health insurer. At the same time, despite advances in biomedical science, medicine, and public health, health care quality remains inconsistent. In fact, underuse, misuse, and overuse of various services often put patients in danger. Many efforts to improve this situation are focused on Medicare, which mainly pays practitioners on a fee-for-service basis and hospitals on a diagnoses-related group basis, which is a fee for a group of services related to a particular diagnosis. Research has long shown that Medicare spending varies greatly in different regions of the country even when expenditures are adjusted for variation in the costs of doing business, meaning that certain regions have much higher volume and/or intensity of services than others. Further, regions that deliver more services do not appear to achieve better health outcomes than those that deliver less. Variation in Health Care Spending investigates geographic variation in health care spending and quality for Medicare beneficiaries as well as other populations, and analyzes Medicare payment policies that could encourage high-value care. This report concludes that regional differences in Medicare and commercial health care spending and use are real and persist over time. Furthermore, there is much variation within geographic areas, no matter how broadly or narrowly these areas are defined. The report recommends against adoption of a geographically based value index for Medicare payments, because the majority of health care decisions are made at the provider or health care organization level, not by geographic units. Rather, to promote high value services from all providers, Medicare and Medicaid Services should continue to test payment reforms that offer incentives to providers to share clinical data, coordinate patient care, and assume some financial risk for the care of their patients. Medicare covers more than 47 million Americans, including 39 million people age 65 and older and 8 million people with disabilities. Medicare payment reform has the potential to improve health, promote efficiency in the U.S. health care system, and reorient competition in the health care market around the value of services rather than the volume of services provided. The recommendations of Variation in Health Care Spending are designed to help Medicare and Medicaid Services encourage providers to efficiently manage the full range of care for their patients, thereby increasing the value of health care in the United States.
Medicare Part D-Kathleen M. King 2009-02 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit, known as Medicare Part D. The Centers for Medicare and Medicaid Services (CMS) contracts with private companies to serve as Part D sponsors and administer the Part D prescription drug benefit plans. The MMA requires Part D sponsors to implement programs to control for fraud and abuse. This report examines: (1) the extent to which certain Part D sponsors have implemented programs to control fraud, waste, and abuse; and (2) the extent of CMS¿s oversight of Part D sponsors¿ programs to control fraud, waste, and abuse. Includes recommendations. Charts and tables.
Medicare/medicaid Fraud and Abuse-Angela Luby Holt 1980
The Law of Medicare and Medicaid Fraud and Abuse-Timothy S. Jost 2000
The Federal Anti-Kickback Statute and Safe Harbors-Geoffrey R. Kaiser 2020 "Introduces reader to the Anti-Kickback Statute, provides specific statutory exceptions and Safe Harbors and reviews interplay between the Anti-Kickback Statute and other laws"--
Healthcare Fraud-Rebecca S. Busch 2012-05 "This second edition provides comprehensive guidance on auditing and fraud detection for healthcare providers and company healthcare plans. New chapters have been added covering a comprehensive auditing model developed by the author on all of the key elements that must be addressed: Primary Healthcare, Secondary Healthcare, Information/Data Management and Privacy, Damages/Risk Management, and transparency. In addition to six new chapters, the current edition material will all be updated and brought up to date"--Provided by publisher.
Medicare improper payments : while enhancements hold promise for measuring potential fraud and abuse, challenges remain : report to congressional requesters-
Health Care Fraud and Abuse-Linda A. Baumann 2007 Baumann (of Arent Fox LLP in Washington, DC) presents a general information reference resource for attorneys working in the field of health law that has been revised so as to be current through May 2007, although some material has been updated past that date in order to cover significant new developments, such as the new Stark III regulations issued in September 2007. Following the introduction, nine chapters address federal physician self-referral restrictions; application of the substantive, qui tam, and voluntary disclosure provisions of the False Claims Act in health care prosecutions; practical considerations for defending health care fraud and abuse cases; legal issues surrounding hospital and physician relationships; risk areas in managed care fraud and abuse for government program participants; corporate compliance programs; potential liabilities for directors and officers of health care organizations; disclosure of qui tam suits and investigations; and control of fraud, waste, and abuse in the Medicare Part D Program.
Medicare Laboratory Payment Policy-Institute of Medicine 2000-12-04 Clinical laboratory tests play an integral role in helping physicians diagnose and treat patients. New developments in laboratory technology offer the prospect of improvements in diagnosis and care, but will place an increased burden on the payment system. Medicare, the federal program providing coverage of health-care services for the elderly and disabled, is the largest payer of clinical laboratory services. Originally designed in the early 1980s, Medicare's payment policy methodology for outpatient laboratory services has not evolved to take into account technology, market, and regulatory changes, and is now outdated. This report examines the current Medicare payment methodology for outpatient clinical laboratory services in the context of environmental and technological trends, evaluates payment policy alternatives, and makes recommendations to improve the system.
Medicare-Leslie G. Aronovitz 1997
Medicare and You-Nancy-Ann Minn DeParle 1998-06 Contents: recent legislation included Medicare+Choice, which will result in changes to the Medicare program; you now have new preventive health benefits & new patient protections. In addition, starting in 1999, Medicare will offer new health plan choices. This handbook includes a description of the new preventive benefits available to you, the rights you have as a patient, & the new health plan options available to you. It will help you identify some of the important questions you will want to ask & includes a list of important resources for you to get more information.
Medicare & You 2021-Centers for Medicare and Medicaid Servic 2020-09-13 This is a handbook for choosing your Medicare coverage. It is a low cost print edition of a government publication.
Principles of CPT Coding-American Medical Association 2016-12-01 Principles of CPT Coding, ninth edition, is a best-selling resource that provides education on CPT billing and guidelines. It offers valuable training on how to code correctly with CPT.
Health Law Handbook-Alice G. Gosfield 1989-04-01 This text brings together the principal legal issues affecting the health care industry. The newest developments in health care, and their implications, including the problems created by the AIDS epidemic and the tensions in critical care decosopm-making are discussed, as are many other topics.
What is ... the Anti-kickback Statute?-Thomas S. Crane 2015 Learn how the Anti-Kickback Statute protects the healthcare system and beneficiaries from the influence of money on referral decisions.
Health Care Mergers and Acquisitions Answer Book-Andrew L. Bab 2018-09-07 M&A activity in the health care industry is at its highest level since the 1980s. Organized into four parts, this guide includes practical advice on how to address the various industry-specific issues arising in health care acquisitions.
Health Care Fraud and Abuse Control Program: Improvements Needed in Controls over Reporting Deposits and Expenditures-Kay L. Daly 2011-08 To help combat fraud and abuse in health care programs, Congress enacted the Health Care Fraud and Abuse Control (HCFAC) program as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires that the Depts. of Health and Human Services (HHS) and Justice (DoJ) issue a joint annual report to Congress on amounts deposited to and appropriated from the Fed. Hospital Insur. Trust Fund for the HCFAC program. This review assesses the extent to which HHS and DOJ: (1) took actions

to address the recommendations made in a 2005 report; and (2) designed effective controls over reporting HCFAC deposits and expenditures for FY 2008 and 2009. Charts and tables. This is a print on demand report.
Medicare Home Health-William Scanlon 1997

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